DELTA DENTAL

SGP Non-Voluntary Plans

SGP Employer Application and Eligibility Statement

Section I: Group Identification

Employer (Group) Name Safe Site Educational Center

Employer's Industry (describe) _____ NAIC# _____

Federal Tax ID# 27-1492193

Requested Coverage Effective Date: First day of Sept 1, 2017 Company headquartered in NM? ☐ Y ☐ N

Has this Group been previously covered by Delta Dental? ☐ Y ☒ N

If yes, prior Group number _____ Term. Date _____

Street Address 1800 Main St NE City Los Lunas State NM Zip 87031

Mailing Address PO Box 1195 City Los Lunas State NM Zip 87031

Billing Address _____ City _____ State _____ Zip _____
(if different from above)

Contact Information:

	Name	Title	Phone	Email
Contract Administration & Renewals (officer)	Lissa			
Benefit Administration (day to day)	Lissa Guzman	HR	505-306-7265	
Billings and Payment	Lissa Guzma			
Eligibility (submission, error/overage reports)	Lissa Guzman			
Third Party Administrator, *if applicable*	Rebecca Gron	Agent	575-626-8797 rebeca.e.advantagebenefitconsultants.com	

Automatic Draft Option for future premium payments ☐ Yes ☐ No If "Yes," please attach completed Automated Clearing House Authorization Form

BMT Security Administrator *(responsible for assigning security to other users within the Group, if multiple BMT users are required)*

Name Lissa Guzma Title _____ Phone 505 3067265 E-Mail lissaaguzman@yahoo.

This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.

Section II: Benefits and Network

	Single Network Plan			OR	Point of Service Plan	
Plan Design:	☐ Plan IA	☐ Plan I	☐ Plan II		☐ Plan IIIA	☐ Plan IIIB
Provider Network:	☐ Delta Dental Premier®	☐ Delta Dental PPO℠			*All Point of Service (POS) plans combine Delta Dental PPO and Delta Dental Premier as in-network options.*	

Preventive Care Security Option:
(Diagnostic and Preventive Services never count against the Annual Maximum) ☒ Yes ☐ No

Plan Maximums Options: *(N/A to Plan III POS A or B)*
Refer to the Underwriting Guidelines for Group size and other requirements related to Plan Maximums.
☐ $1,000 ☒ $1,500 (10+ enrolled) ☐ $2,000 (10+ enrolled)

Orthodontic Services (may select if 20 or more employees enrolling or if 10 or more enrolling and Group has prior Ortho):
☐ Child only ☐ Child and adult N/A

Does the Group currently have a dental plan? ☐ Yes ☒ No Carrier _____

Premiums/Rating Tier Selected

Indicate below the monthly premiums for the plan selected. *(Rates shown should include options and rating adjustment(s) for no prior dental or Specified Industry, if applicable. Refer to the Delta Dental SGP Underwriting Guidelines for more information.)*

	3-TIER RATES		4-TIER RATES		ENROLLMENT	TOTAL
Employee Only	$ _____		$ 33.30	X _____		$ _____
Employee + 1	$ _____	OR	$ 66.60	X _____		+ $ _____
Employee + Family	$ _____		$ 78.25	X _____		+ $ _____
			$ 124.15	X _____		+ $ _____
					Group's first-month deposit check will be in the amount of:	= $ _____

Section III: Enrollment, Eligibility, and Billing

A reasonable number of billing subgroup numbers, which distinguish classes of employees (by department, location, etc.) on the monthly billing statements, are available subject to underwriting approval. If Group is subject to COBRA, a subgroup will automatically be assigned.

Is Group subject to COBRA? ☒ Yes ☐ No

Subgroup(s) requested? ☐ Yes ☒ No If "Yes," please request and complete a Subgroup Information Page Addendum for this application.

Full-time employees are considered eligible to enroll if they work 30 **hours per week.**
Seasonal, temporary, and part-time employees not meeting the hourly requirement shown above will not be eligible for coverage.

The Eligibility Waiting Period is first of the month following 60 **days OR** _____ **months of employment.**
*(Please Note: Date of hire is NOT an option for the Eligibility Waiting Period.)

Does the waiting period apply for all classes of employees? ☒ Yes ☐ No If "No," please explain on the lines provided below:

_____

_____

Coverage for Domestic Partners ☐ Yes ☐ No If "Yes," Delta Dental of New Mexico reserves the right to request a copy of the Group's domestic partner policy at any time for verification.

Age 26 Enhanced Dependent Eligibility Option *(no additional cost)* ☐ Yes ☐ No
Dental benefits are excepted from the ACA requirement to cover dependents up to age 26. If the Group chooses the enhanced dependent eligibility option, it will apply regardless of employment, marital, student, or dependent status, or the child's eligibility for other coverage.

By selecting "Yes" above, Group agrees with the following statements:
1. Dental plans are not subject to the PPACA expanded definition of eligibility for children.
2. This enhanced eligibility definition is optional. Delta Dental is not requiring or recommending a change from standard dependent definition.

3. Because this expanded dental plan definition is not mandated by law, there is the potential for some tax or other implications. The Group acknowledges the importance of receiving independent legal/tax counsel relative to the impact of an eligibility change.

Pediatric Dental Essential Health Benefit Option *(will require rating adjustment)*
Delta Dental now offers the Pediatric Dental Essential Health Benefit. Please contact your Broker or Sales Representative for more information.

Census

A.	**TOTAL number of employees** *(full-time, part-time, seasonal, etc.)*		28
B.	**Ineligible employees**		
	(i) Part-time, seasonal, or temporary (ineligible)		
	(ii) In probationary period (have not met Employer's Eligibility Waiting Period)	+	
C.	**Total number of ineligible employees**	=	
D.	**Eligible employees (A minus C)**		
E.	**Number of employees enrolling with Delta Dental (must be at least 50% of Line D)**		
F.	**Eligible employees not enrolling with Delta Dental due to other dental coverage (waivers required). E plus F must be at least 75% of eligible employees (D).**		
G.	**Employees not enrolling with Delta Dental (waivers required).**		
	Total E+F+G (should match total number of eligible employees shown on Line D)		

Section IV: Employer Signature and Acknowledgment

The premium contribution made by the Employer (Group) toward the cost of each employee's coverage in this dental plan will be: _____ % of the Employee Only premiums shown above and _____% of the cost of any dependent coverage they may elect.

I understand that coverage cannot be bound by my agent; that my prior dental plan, if any, should not be terminated until coverage is approved by Delta Dental; and that coverage is subject to the Delta Dental Underwriting Guidelines, a copy of which is available to me upon request. I acknowledge that this Group Application will be the basis of any Group contract written by Delta Dental for my Group and believe that all information provided herein is accurate to the best of my knowledge.

I understand that the dental plan selected on this application includes a free-of-charge discount vision plan through VSP; that Delta Dental will share member information with VSP for the sole purpose of administering the discount vision plan; and that the discount vision plan is not a fully insured vision plan and only provides discounts on vision services.

Typed/printed name of Group Officer _____ **Title** _____

Executed this _____ **day of** _____, **20** _____

Authorized Signature (Group Officer) _____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Section V: Agent Data, Signature, and Acknowledgment

Individual Agent Name Rebecca Groh Agency Name Advantage Benefit

Street Address 805 W Hermosa City Artesia State NM Zip 88210

Telephone (575) 626-8797 Fax (____) _____ E-Mail Address rebecca@advantagebenefitconsultants.com

Mailing Address (if different from above) PO Box 1393 Artesia 88211

Agent Initials RHG

The information provided by the employer on this Group Application is accurate to the best of my knowledge and I believe this Group meets the requirements stated in the Delta Dental Underwriting Guidelines, a copy of which has been provided to me.

Executed this _____ **day of** _____, **20** _____, **Agent Signature** _____

This quote module is for illustrative purposes. Final rates will be based off of birthdate on enrollment form.

Group Name:	**Safe Site**		**Broker:**	**no broker**	
Zip Code:	**87031**	ITER: **1**	**BrokerNPI:**		
Effective Date:	**9/1/2017**				

Plan Name	Mbr Type	First & Last Name	DOB	AGE	Total Cost	Employer Cost	Employee Cost
HMO Platinum 1	Employee	Miranda Candelaria	3/18/1998	19	$233.63	$116.82	$116.81
HMO Platinum 1	Employee	Marissa Candelaria	5/29/1995	22	$367.92	$183.96	$183.96
HMO Platinum 1	Employee	Sarah Candelaria	2/18/1964	53	$750.55	$375.28	$375.27
HMO Platinum 1	Dependent	Child	1/1/2004	13	$233.63	$0.00	$233.63
HMO Silver 5	Employee	Samuel Gonzales	2/23/1999	18	$139.93	$69.97	$69.96
HMO Silver 5	Employee	Nate Candelaria	3/4/1998	19	$139.93	$69.97	$69.96
HMO Silver 5	Employee	Maria Guadalupe-Perez	10/27/1971	45	$318.21	$159.11	$159.10
HMO Platinum 1	Employee	Lissa Guzman	1/9/1971	46	$551.88	$275.94	$275.94
		Total Monthly Premium			$2,735.68	$1,251.05	$1,484.63

Employer Signature

8-10-17
Date

Employer Contribution		Percentage	Dollar Amount
	Employee	50%	
	Spouse		
	Dependent		

PRESBYTERIAN

EXHIBIT B

AUTHORIZATION AGREEMENT FOR PREARRANGED PAYMENTS

Felix Cudelaria Sr hereby authorizes and requests Presbyterian to initiate and withdraw entries from the account indicated below and the financial institution named below for monthly premium payments required by the Group Subscriber Agreement/Summary Plan Description.

This authorization is to remain in effect until Presbyterian and the financial institution named below are notified in writing. I understand that I have the right to terminate this agreement by notifying my financial institution. However, I understand that prearranged withdrawal entries are the required method of premium payment under the Group Subscriber Agreement/ Summary Plan Description.

Name of Financial Institution WellsFargo

Financial Institution Transit Routing Number (9 digits) 107002192

Name on Financial Institution Account Safe Site Youth Development

Account Number [redacted]

Circle Type of Account (Checking) Savings

Signature
(must be on Financial Institution Signature Card)

8-10-17
Date

YOU MUST ATTACH A VOIDED CHECK OR DEPOSIT SLIP FOR FINANCIAL INSTITUTION AND ACCOUNT INFORMATION VERIFICATION.

Rev 8/09

PRESBYTERIAN

EMPLOYER GROUP INFORMATION SHEET

Instructions:

1. Complete the following information and fax to **505-923-8163** or email to: pressalesrfp@phs.org.
2. All forms are also available on our website at www.phs.org.

Group Information		
Company Tax ID#: 271492193	Requested Effective Date: Sept 1, 2017	
Exact Legal Name of Company: Safe Sik Youth Development Inc.		
Physical Address: 1800 Main ST NE	City/State: Los Lunas NM	Zip: 87031
Company Contact Name: Lissa Guzman	Title: HR	
Email: lissaaguzman@yahoo.	Phone: (505) 306-72	Fax:
Billing Contact Name:	Title:	
Billing Address: SAME ↑	City/State:	Zip:

Is this company affiliated with any other companies? ☐ Yes ☒ No
If yes, affiliated company name: _____
What is your company type? ☐ LLC Corporation ☐ Sole Proprietorship ☐ Other: INC.
What is affiliated company type? ☐ LLC Corporation ☐ Sole Proprietorship ☐ Other: _____

Eligibility Provisions

Does employer wish to waive the waiting period for initial enrollment? ☒ Yes ☐ No
New hired employee coverage commences on: The 1st of the month following 60 days from date of hire (60 days max.) **OR**
30-day orientation period applies? ☐ Yes ☒ No **(see amendment – "Explanation of 30-Day Orientation Period")**
Full-time Eligible Employees scheduled to work 30 hours per week. (**30 hrs. max**.)

COBRA Eligibility Information

Total Number of COBRA participants: _____
Do you:
Administer your own COBRA? ☐ Yes ☐ No
Use other COBRA Administrator? ☐ Yes ☐ No
If yes, who: _____
Want to use Presbyterian's COBRA? ☐ Yes ☐ No
If yes, then: ⟶

In what format do you want to receive COBRA information? ☐ PGP ☐ Zip
Do you want former EE's to make COBRA elections online? ☐ Yes ☐ No
Should individual policy information be sent a cancellation notice? ☐ Yes ☐ No

Are you purchasing a qualified high deductible health plan? ☐ Yes ☒ No

Will you be offering an HSA through Presbyterian? ☐ Yes ☐ No
*Please complete the Health Equity HSA Info Form.

Group Census Information

Group attests that they have 51 or more full-time equivalent employees based on IRS guidelines. ☐ Yes ☐ No

Indicate Employer Contribution:

Single Employee _____% or $ _____
Spouse _____% or $ _____
Dependent _____% or $ _____

Metal Plan Selection:

☐ Platinum
☐ Gold
☐ Silver
☐ Bronze

Total Employees (EE's):	=	29
# Part-time/Seasonal EE's:	-	3
# EE's in Waiting Period:	-	0
# Eligible EE's (include waiver):	=	26
# EE's waiving w/o other coverage:	-	
# EE's waiving with other coverage:	-	
Total EE's enrolling:	=	8
# Out of Area EE's:	=	

Group attests that the foregoing employee counts are accurate to the best of Group's knowledge, and Group acknowledges that Group is solely responsible for determining such employee counts. ☐ Yes ☐ No

Producer Information		
Producer Name: Rebecca	Phone: 505-626-8797	Fax:
Producer Agency: Advantage	Email: rebecca@advantagebenefitconsultants.com	